phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Prevention

My health for life

MODULE

Date: June 2022

Version: 4

The quality improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply
- Reduced risk by starting small
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements.

There is an example of how to increase referrals to the *My health for life* program for people with high cholesterol using the MFI and a blank template for you to complete at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to ongoing development in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Toolkit aim - To identify who in your practice is eligible for the My health for life program and to ensure patients are referred.

To achieve this, you will need to extract patient data and establish a valid patient list or register.

The following activities will help guide you through the process. There are additional activities to find any patients who may have been missed in the initial data extraction activity and to ensure they are then coded correctly. These activities will improve the accuracy of the register and maintain the system for the future.

Please note: completing the data tables alone in the workbooks does not constitute a quality improvement activity. They are designed to inform areas for QI and that a MFI should be completed to meet PIP QI requirements.

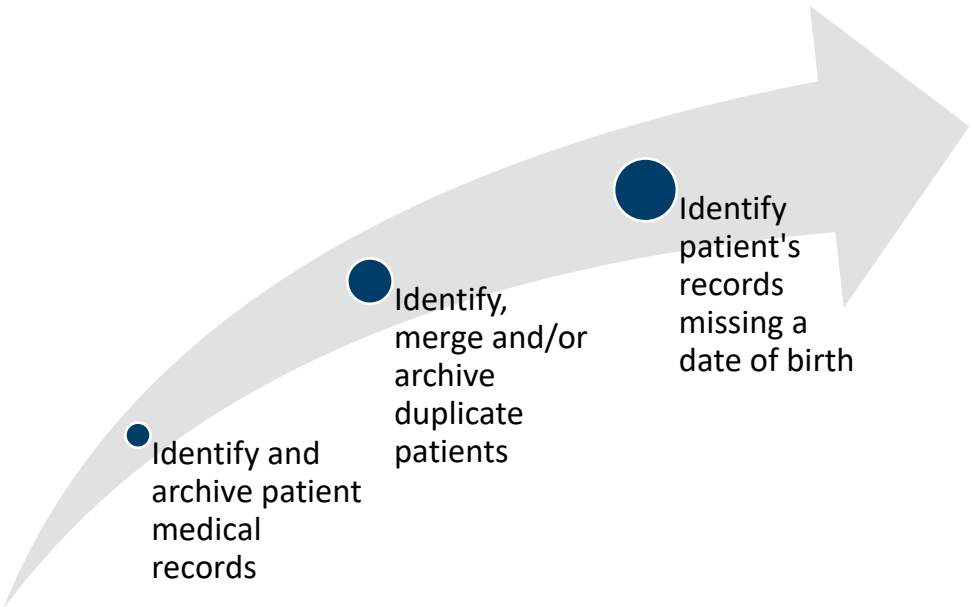
How to use this toolkit

There are checklists included below that will guide you and your practice to:

- Identify a sample group of patients by reviewing data measures from your practice population.
- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- Review your process and start again if you find your process is not working and you are not seeing improvements.

Before you begin

To ensure your practice database is as accurate as possible it is suggested that you complete the following activities prior to completing this toolkit:



1. **Identify and archive patient medical records** - before completing a bulk archive of patients, it is important to follow practice policy on the agreed timeframe for the last visit of the patient to the practice. The following instructions outline the process to bulk archive inactive patients within the clinical software Best Practice, MedicalDirector, PractiX and Genie.
2. **Identify, merge and/or archive duplicate patients** - follow the duplicate patients report instructions. This search will look for matches on surname, first name initial, gender and date of birth; and produce a report.
3. **Identify patient records missing a date of birth** - follow the instructions to identify patient records missing date of birth.

For more support

support@bsphn.org.au

1300 467 265

Contents

My health for life overview

My health for life (MH4L) is a free behaviour change program designed for people at risk of developing a chronic disease including cardiovascular disease or diabetes. The program shows participants that making small lifestyle changes can have major health benefits. Participants take part in small group programs or one-on-one phone coaching. The program is delivered by trained health professionals via six sessions over a six-month period.
PLEASE NOTE: The program has been extended from previously high risk only, to include low and medium risk also.

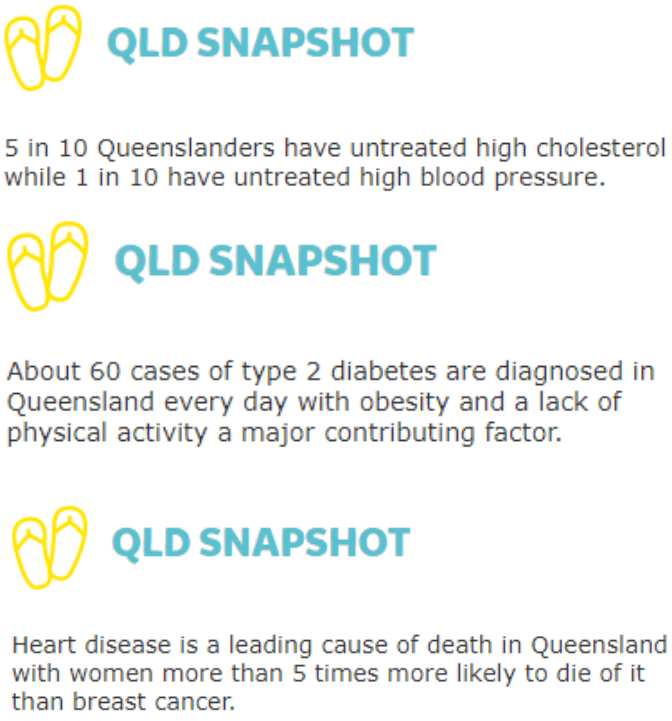
Recent changes to the program

Recently the MH4L program has broadened the eligibility criteria to include:

- Age reduced from 45 to 18+ years.
- Included waist circumference.
- New cohorts – those at low and moderate risk of chronic disease.
- Vulnerable population commencers targets:
    - Low socioeconomic status
    - Aboriginal and Torres Strait Islander
    - Culturally and linguistically diverse (CALD)
    - Rural and remote
    - Men.

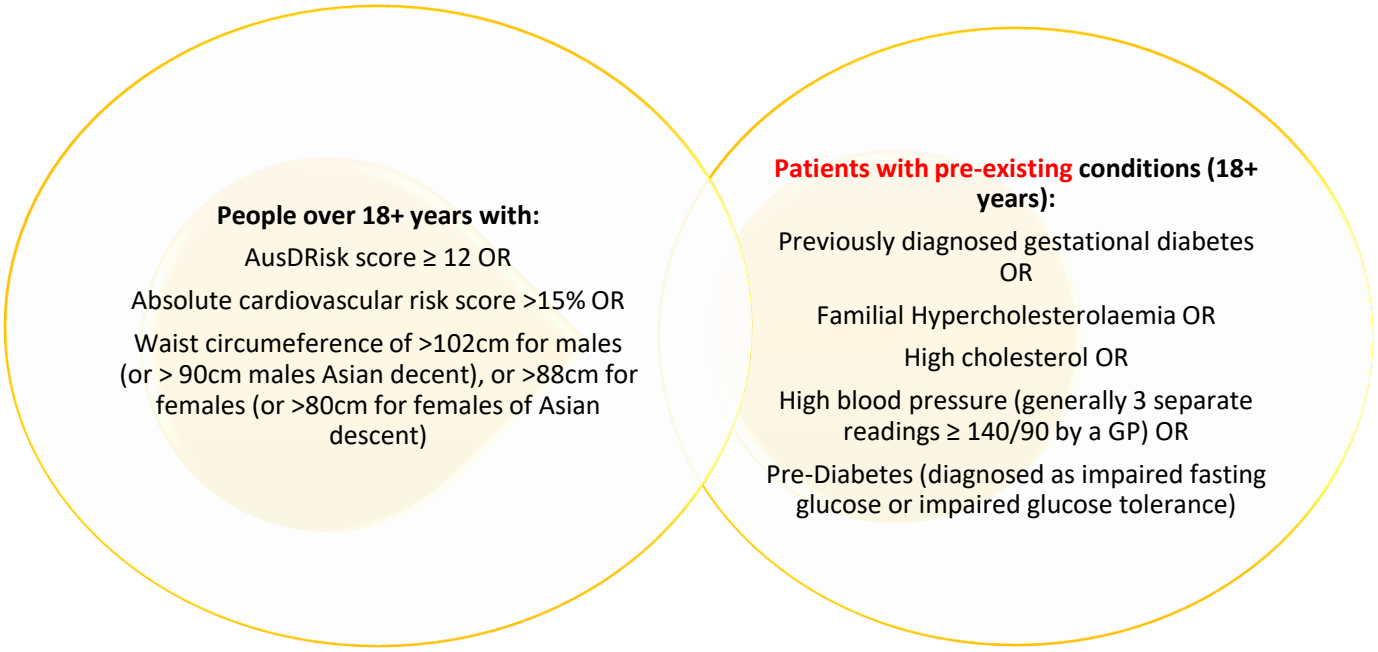
My health for life program goals

- To effectively identify people at risk of developing chronic disease, and provide them with an appropriate behaviour modification program.
- To increase health literacy levels and the capacity of program participants to adopt and maintain positive health behaviours to manage their health risk factors.
- To improve community awareness, knowledge and attitudes about chronic disease risk factors and how to make positive health behaviour choices.



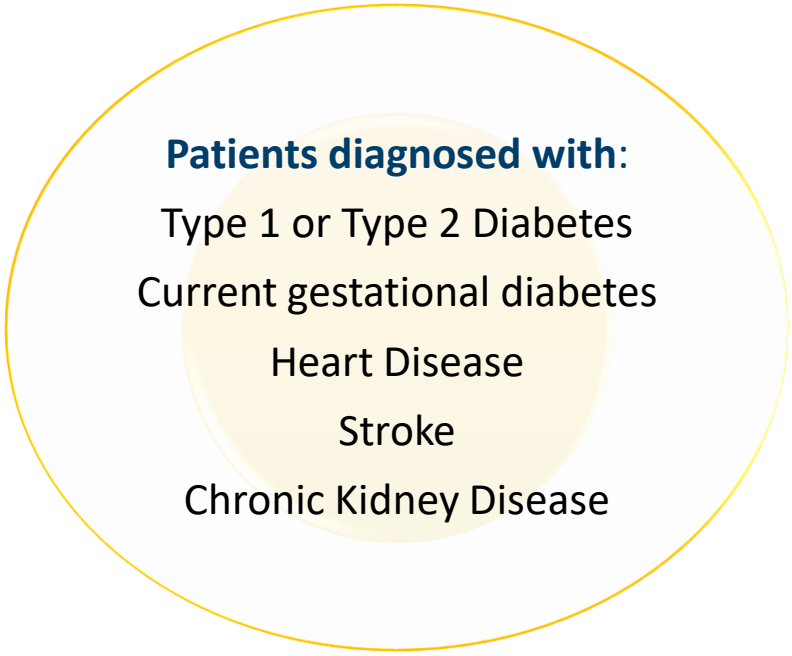
What are the criteria to participate in the *My health for life* program?

People at risk of cardiovascular disease or diabetes including:

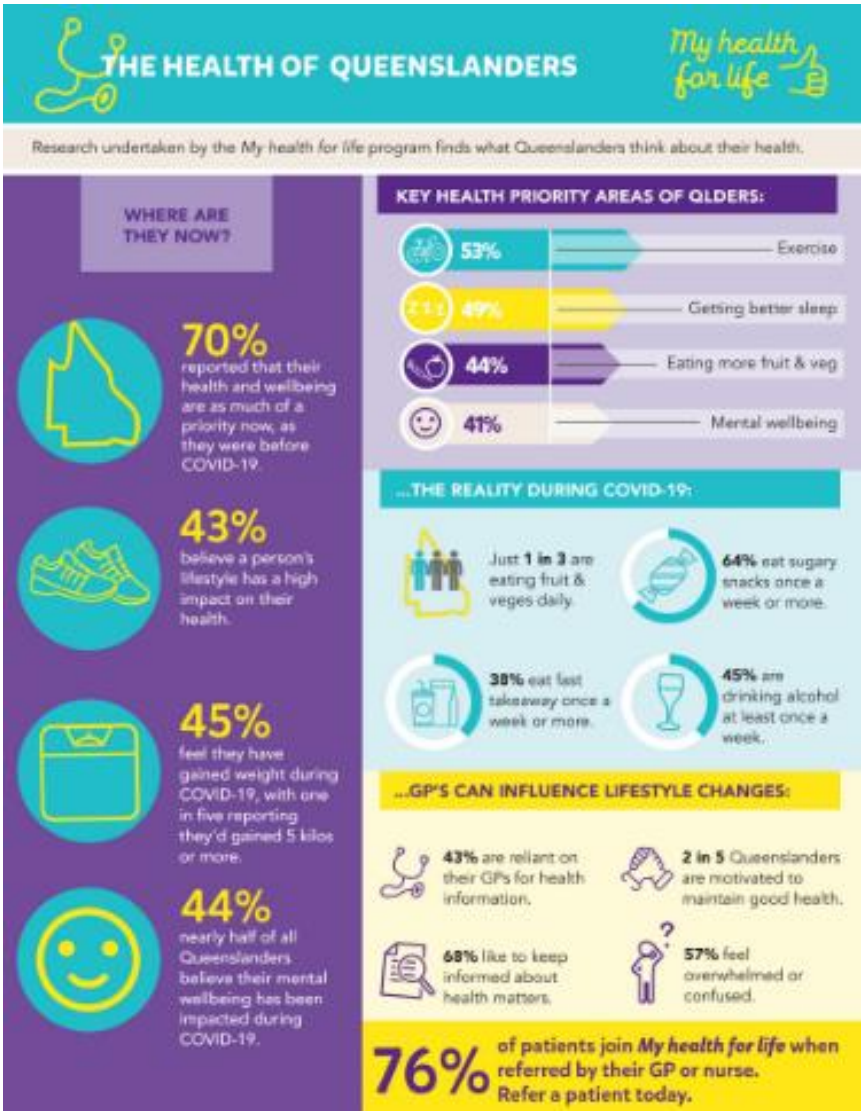


Who is ineligible to participate in the *My health for life* program?

Patients with existing disease including:



MH4L program findings at a glance



Activity 1. Understanding your patient population

Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients who may be eligible for the My health for life program.

Complete the below table by collecting data from your CAT4 Data Extraction Tool to gather information on your patient population.

Note - Instructions on how to extract the data are available on the CAT4 website: *My health for life* OR high risk patients eligible for MH4L OR indigenous patients eligible for MH4L OR patients eligible for MH4L with high CV event risk OR patients with familial hypercholesterolaemia eligible for MH4L OR patients with high blood pressure eligible for MH4L OR patients with high cholesterol eligible for MH4L.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Number of patients at high risk eligible for the *My health for life* program		
1.1b	Number of Indigenous patients eligible for the *My health for life* program		
1.1c	Number of patients with high CV event risk eligible for the *My health for life* program		
1.1d	Number of patients with familial hypercholesterolaemia eligible for the *My health for life* program		
1.1e	Number of patients with high blood pressure eligible for the *My health for life* program		
1.1f	Number of patients with high cholesterol eligible for the *My health for life* program		

Please note: the RACGP defines active as 3 visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.

Activity 1.2– Reviewing your patient's eligible for the *My health for life* program

Complete the checklist below which reviews your practice's patients eligible for the My health for life program.

Description	Status	Action to be taken
After completing **activity 1.1** are there any unexpected results with your practice's patients eligible for the *My health for life* program?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. larger number of patients with high absolute CVD risk or only a low number of patients with high cholesterol eligible for the program).* How will this information be communicated to the practice team?
Have you created a Topbar prompt on all patients who may be eligible for the *My health for life* program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Topbar instructions.
 After reviewing your practices *My health for life* profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.3 – Data collection from CAT4

The aim of this activity is to collect data to identify patients who are missing cardiovascular event risk data to ensure data is correctly entered.

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website.

Cardiovascular disease (CVD) event risk factors include: smoking, cholesterol, HDL, BP, age and gender.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.3a	Number of patients with incomplete CVD risk factor data recorded		
1.3b	Number of patients with 3 or more CVD risk factor event measures incomplete		

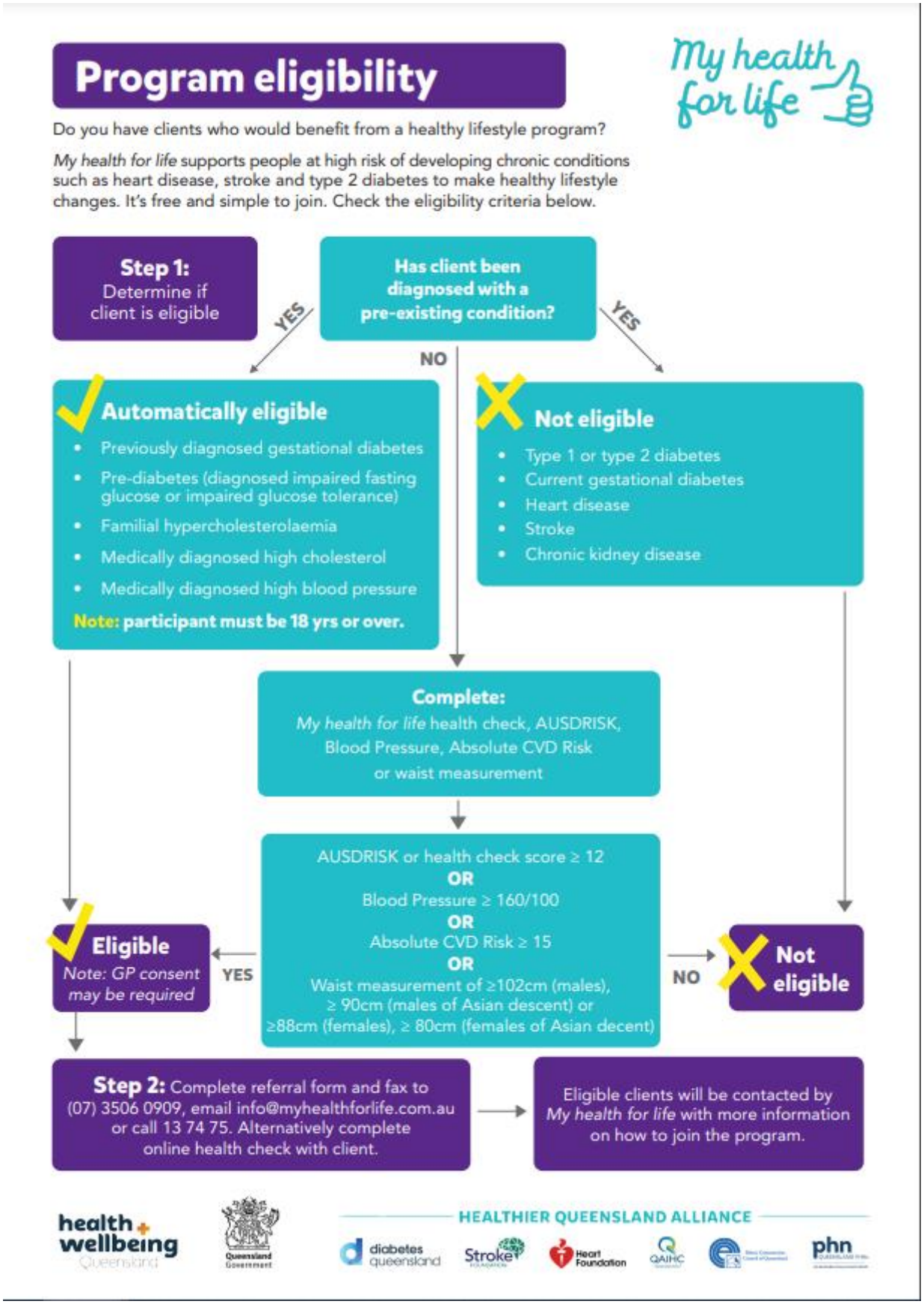
Please note: after you have completed this activity and any missing data is entered, you may find other patients eligible for the *My health for life* program.

Activity 1.4– Reviewing your patients with incomplete CVD event risk assessment data recorded

Complete the checklist below which reviews your practice's patients with incomplete CVD event risk data

Description	Status	Action to be taken
After completing **activity 1.3** are there any unexpected results with your practice's incomplete CVD risk assessment data?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*for e.g. high number of patients with 3 or more risk factors missing)* How will this information be communicated to the practice team?
Have you created a Topbar prompt on all patients who have incomplete CVD risk assessment data?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Topbar instructions.
Do you know how to generate the report for individual providers?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to CAT4 instructions.
After reviewing your practice's incomplete CVD risk assessment data, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 2. My health for life referral process & patient journey

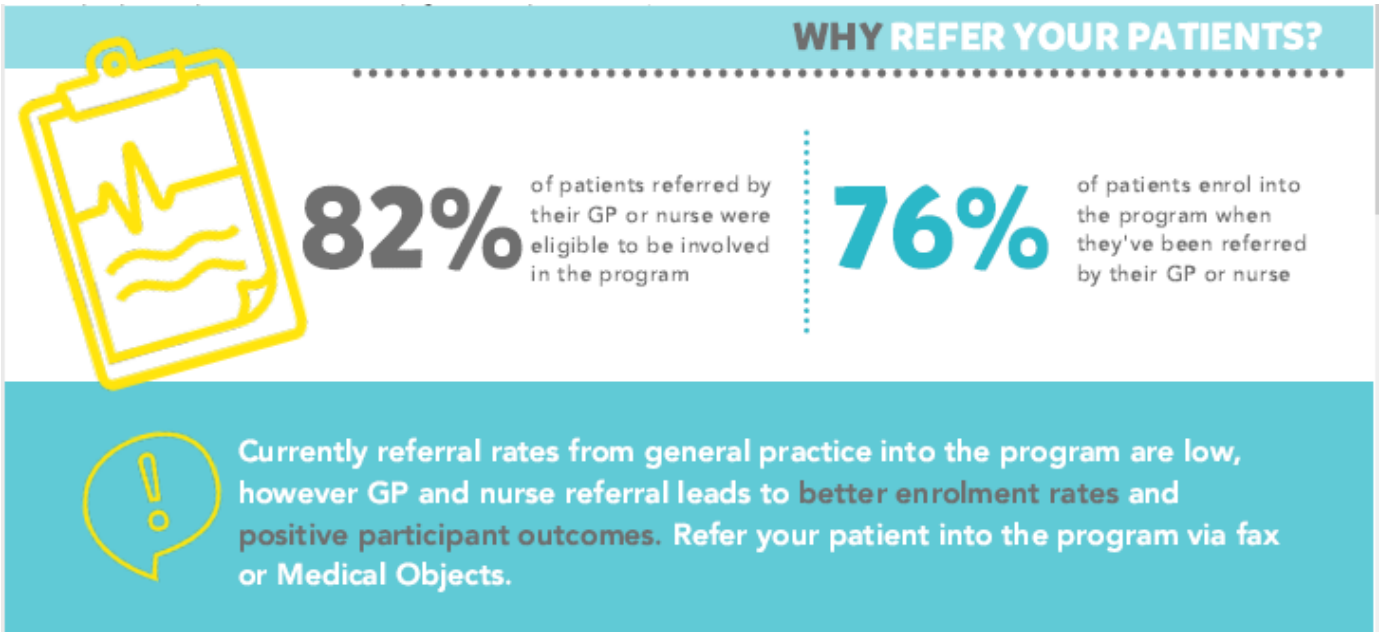


My health for life referral form templates

GP referrals are sent to the *My health for life* team at Diabetes Queensland via Medical Objects or fax 07 3506 0909.

My health for life referral templates are available in Best Practice and MedicalDirector – under 'Supplied Templates'. In Best Practice it's called 'My health for life' and in Medical Director it's called 'Referral – My health for life'.

Although GP referral is recommended, referrals can also be made by a practice nurse, allied health professional or the patient themselves by contacting 13 RISK (13 7475) or visiting the website to complete a health check.



Patients that self-refer into the program will require GP consent if they have any of the following:

- pregnant
- mental health issues
- current acute illness (i.e. cancer)
- surgery within the last 12 months
- high blood pressure either >160 systolic or >100 diastolic.

Activity 2.1– Review referral process for the *My health for life* program

The aim of this activity is to review your referral process for the My health for life program.

Description	Status	Action to be taken
Do relevant team members know the eligibility criteria for the *My health for life* program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to eligibility criteria.

Description	Status	Action to be taken
Are electronic referral templates available on your clinical software package?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to relevant referral templates. How will you let the team know that referral templates are now available?
 After reviewing your *My health for life* referral process, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3. *My health for life* and RACGP accreditation standards

RACGP 5th Edition Accreditation Standards & preventive health

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Criterion C4.1 – Health Promotion and Preventive Care

C4.1A - Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

According to the accreditation standards, assessing a patient's health risks and early detection of disease are important components of preventive care. It is a requirement of the standards that practices must document in the patient's health records discussions or activities relating to preventive health.

Strategies that practices may implement include are to:

- use preventive health guidelines and resources
- hand out up-to-date pamphlets and brochures
- provide information on the practice's website
- run preventive health activities, such as diabetic education groups and groups to help patients quit smoking
- have a reminder system to prompt patients of screening activities.

Activity 3.1– Reviewing your practice's preventive health activities

Complete the checklist below which reviews your practice's preventive health activities.

Description	Status	Action to be taken
Does your practice have preventive health guidelines available to relevant team members?	☐ Yes: **see action to be taken.**	Are the guidelines up to date? ☐ Yes ☐ No How often are the guidelines checked for currency? ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____ Who has the responsibility to check for up to date guidelines? _____
	☐ No: **see action to be taken.**	Refer to the RACGP Guidelines for Prevention in General Practice.

Description	Status	Action to be taken
Do relevant team members encourage patients to complete the *My health for life* risk assessment?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Encourage patients to complete the online *My health for life* risk assessment. Ask nursing staff to complete initial risk assessment with patients.
Does relevant team members talk with identified high-risk patients and refer them to the *My health for life* program?	☐ Yes: continue with activity. . ☐ No: **see action to be taken.**	Assess readiness for change and refer to the program.
Do health professionals document in the patient's file when preventive health information is provided?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Print patient information brochures from MedicalDirector or Best Practice. This information is automatically documented in the patient file. Discuss at your next team meeting how to ensure relevant team members are documenting information.
 After reviewing your practices preventative health information sharing strategies, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 4. *My health for life* and prevention activities and assessments

General practice is at the forefront of healthcare in Australia and in a pivotal position to deliver preventive healthcare. More than 137 million general practice consultations take place annually in Australia and 85 per cent of the Australian population consult a GP at least once a year. Preventive healthcare is an important activity in general practice. It includes the prevention of illness, the early detection of specific disease, and the promotion and maintenance of health. The partnership between GP and patient can help people reach their goals of maintaining or improving health. Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups. Prevention of illness is the key to Australia's future health – both individually and collectively. About 32 per cent of Australia's total burden of disease can be attributed to modifiable risk factors.[1]

My health for life health score test

People are often unaware of their risk of developing future health conditions because they currently feel okay or there are no obvious signs to indicate that their risk of chronic conditions is high. *My health for life* have an online health check that people can use to determine their personal risk.

Activity 4.1 – Data collection from CAT4

The aim of this activity is to collect data to review preventive health measures in your practice.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data are available from the CAT4 website: Smoking status OR BMI classification OR elevated CV risk OR identify patients at risk of developing type 2 diabetes OR patients with previous fracture OR physical activity script

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
4.1a	Number of patients aged ≥ 18 years who are smokers (*include starting age as 18 on the CAT4 search)*		
4.1b	Number of indigenous patients aged ≥ 18 years who are smokers *(include starting age as 18 and select Indigenous on the CAT4 search)*		
4.1c	Number of patients aged ≥ 18 years who have a BMI classification of overweight, obese and morbidly obese (*include starting age as 45 on the CAT4 search)*		
4.1d	Number of indigenous patients aged ≥ 18 years who have a BMI classification of overweight, obese and morbidly obese *(include starting age as 18 and select Indigenous on the CAT4 search)*		

[1] https://www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition.pdf

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
4.1e	Number of patients aged ≥ 18 years with elevated CV risk (*include starting age as 18 on the CAT4 search)*		
4.1f	Number of indigenous patients aged ≥ 18 years with elevated CV risk *(include starting age as 18 and select Indigenous on the CAT4 search)*		
4.1g	Number of patients aged ≥ 18 years who are at risk of developing type 2 diabetes (*include starting age as 18 on the CAT4 search)*		
4.1h	Number of indigenous patients aged ≥ 18 years who are at risk of developing type 2 diabetes		
4.1i	Number of patients aged ≥ 50 years who have had a previous fracture		
4.1j	Number of patients aged ≥ 18 years with their physical activity status recorded		

Please note: the RACGP defines active as 3 visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.

Activity 4.2– Reviewing your patient's preventive health measures

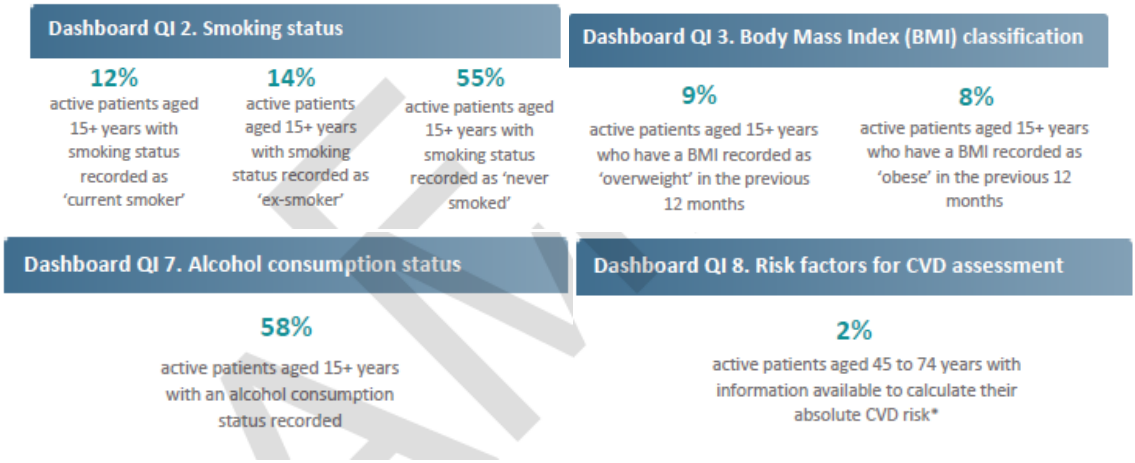
Complete the checklist below to outline the prevention health measures in your practice.

Description	Status	Action to be taken
After completing **activity 4.1** are there any unexpected results with your practice's preventive health measures?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. high number of patients with CVD risk or only a low number of patients with smoking status recorded).* How will this information be communicated to the practice team?
Do relevant team members know where to access the *My health for life* risk assessment tool?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the MH4L risk assessment tool.

Description	Status	Action to be taken
Do relevant team members know where to access the *absolute CVD* risk assessment tool or CVD Check?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information on CVD risk.
Do relevant team members know where to access the type 2 diabetes AUSDRISK assessment tool?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information on AUSDRISK tool.
After reviewing your practices preventative health measures, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 4.3 - PIP QI Measures

As part of the PIP QI measures, practices are to report on smoking status, BMI, alcohol status, risk factors for CVD and cervical screening for prevention activities. A snapshot of your practice progress reporting on this information is available in your latest benchmark report provided by Brisbane South PHN.



	Description	% completed
4.3a	Percentage of active patients aged 15+ years with a smoking status recorded as 'current smoker'	
4.3b	Percentage of active patients aged 15+ years with a smoking status recorded as 'ex-smoker'	
4.3c	Percentage of active patients aged 15+ years with a smoking status as 'never smoked'	

	Description	% completed
4.3d	Percentage of active patients aged 15+ years who have a BMI recorded as 'overweight' in the previous 12 months	
4.3e	Percentage of active patients aged 15+ years who have a BMI recorded as 'obese' in the previous 12 months	
4.3f	Percentage of active patients aged 15+ years with an alcohol consumption status recorded	
4.3g	Percentage of active patients aged 45 to 74 years with information available to calculate their absolute CVD risk	

Activity 4.4 – Review PIP QI measures for preventive measures

The aim of this activity is to review your practice PIP QI measures.

Description	Status	Action to be taken
After reviewing your PIP QI measures from your latest benchmark report, are you happy with your results?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. we have a low % of patients with their BMI recorded*). How will this information be communicated to the practice team?
After reviewing your PIP QI measures, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 4.5 – Recording preventive health results in your clinical software

The aim of this activity is to review if relevant team members know where to record preventive health results in your clinical software program.

Description	Status	Action to be Taken
Are all the preventive health results being recorded in the correct fields in your clinical software? (E.g. height, weight, BMI, smoking status, alcohol status, physical activity).	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Review how and where your preventive health information is being recorded in your practice software. Refer to Brisbane South PHN Quality Patient Records QI Toolkit. Ensure all relevant team members are aware of how to record cardiovascular disease risk factor information. Document in practice policy.
Do relevant staff know where to enter preventive health results in your clinical software package?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions for Best Practice or MedicalDirector. Contact the Digital Health team on ehealth@bsphn.org.au for assistance.
Do relevant team members understand the importance of using drop down lists provided with your clinical software program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to all team members on importance of data entry (Refer to Brisbane South PHN Quality Patient Records QI Toolkit).
 After reviewing where your preventative measures are recorded, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Cardiovascular Risk Calculator

The Australian Absolute cardiovascular disease risk calculator has been produced by the National Vascular Disease Prevention Alliance for the information of health professionals. To use the calculator, you will need the patient's age, blood pressure, smoking status, total and HDL cholesterol and ECG LVH if known. The calculator is included in Best Practice and MedicalDirector.

Managing people at risk of developing Type 2 diabetes

Lifestyle modifications such as physical activity, dietary change and weight loss should be trialled before considering the use of pharmacological interventions for the prevention of type 2 diabetes.

The Australian Risk Assessment Tool (AUSDRISK) should be used to identify people at high risk of developing diabetes.

- A risk score of 12 should be used to categorise high risk.
- Risk assessment should begin at age 40 and from age 18 in Aboriginal and Torres Strait Islanders*.
- Risk assessment should be repeated every 3 years.

* It should be noted that the AUSDRISK may overestimate risk in those under 25 years of age and underestimate risk in Aboriginal and Torres Strait Islanders. In absence of specific strategies targeting a low socio-economic deographic, strategies aimed at the general population are recommended. Culturally appropriate lifestyle interventions should be provided in accessible settings. [2] The calculator is included in Best Practice and MedicalDirector.

How your general practice can get involved

The following list outlines the steps your practice can take to get involved in the *My health for life* program

- Use waiting room promotion
- Use *My health for life* CAT4 recipes and/or review existing CAT4 CVD event risk to help identify and recall at risk patients
- Encourage patients to complete the online *My health for life* risk assessment
- Ask nursing staff to complete initial risk assessment with patients
- Encourage patients to complete the AUSDRISK Calculator
- Talk with the identified high-risk patients about the program, assess readiness for change and refer to the program.

[2] http://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/b1126d58-2763-403a-bd2d-44a241bb9189.pdf

Activity 5. *My* health *for life* and Medicare Benefit Schedule (MBS) item numbers

The aim of this activity is to outline some of the MBS item numbers that you may use in general practice for eligible patients. If you complete one of the MBS item numbers below, you may identify a patient who may benefit from a referral to the My health for life program.

Patients ***may be eligible*** to access chronic disease item numbers within the Medicare benefit schedule. These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number, please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN have a comprehensive toolkit looking at MBS items, however, a summary of the item numbers include:

MBS items

- Health assessment
- Aboriginal and Torres Strait Islander health assessment
- Heart health check

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Heart Health Check (MBS items 699 and 177)

Medicare has an item number, **699 (177 for non VR**), for GP's to conduct a comprehensive cardiovascular health assessment utilising the Australian Absolute Cardiovascular Disease Risk calculator.[3] The Heart Health Check includes absolute CVD risk assessment followed by development of a lifestyle management plan. This plan may include referral to *My Health for Life* or other available lifestyle support programs such as Heart Foundation Walking, Quitline or 10,000 Steps.

A Heart Health Check includes absolute CVD risk assessment and development of a lifestyle management plan. So, referral to *My health for life* can occur during a Heart Health Check.

Who is eligible for a Heart Health Check?

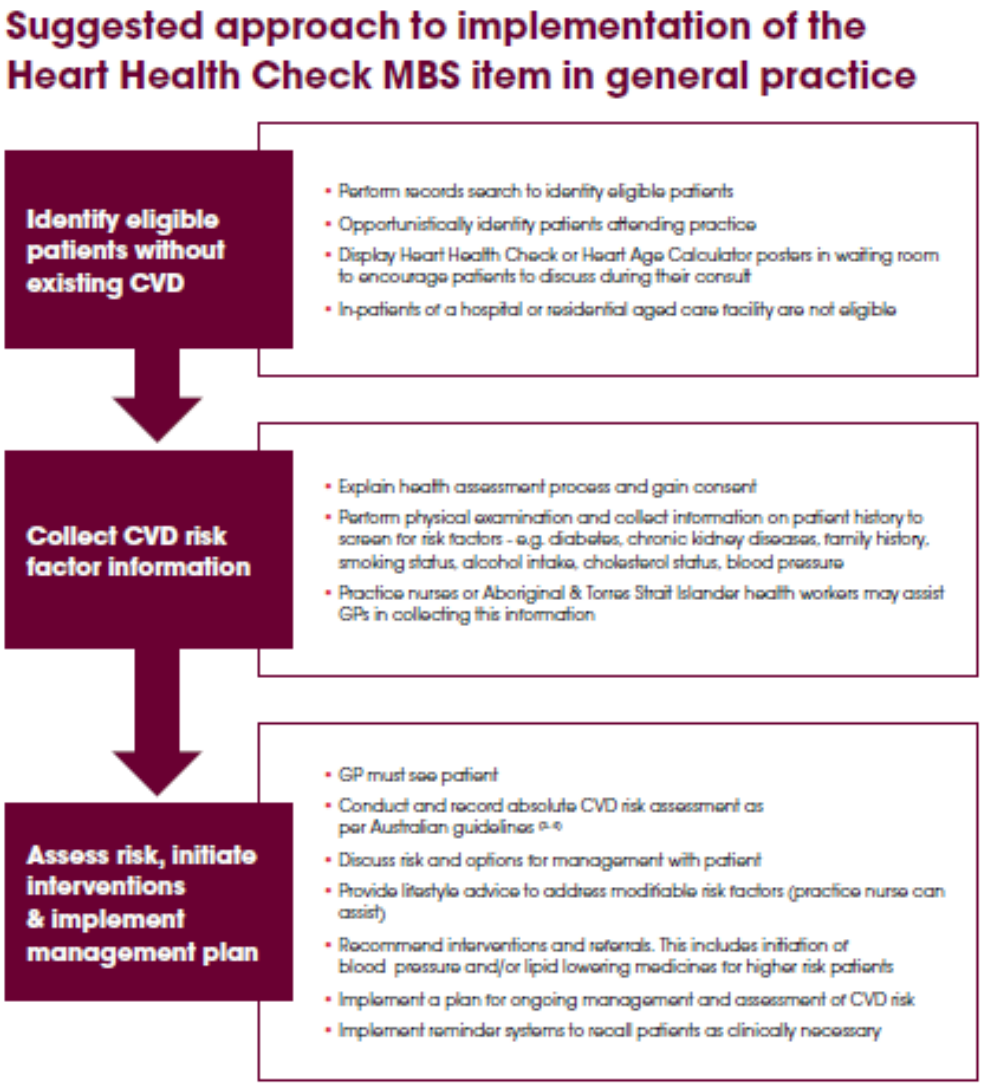
The intention of this item is to identify CVD in people not known to have CVD including:

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above;
- Adults aged 45 years and above, who have not claimed a health assessment in the previous 12 months.

Heart Health Check & the Heart Foundation

The Heart Foundation have a number of resources available to assist general practice to identify and complete Heart Health Checks for eligible patients. One of these resources is a suggested approach to implementation of the Heart Health Check MBS item number in general practice.

[3] *Heart Foundation Australia*



[4]

Activity 5.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of claims made for MBS items at your practice over the past 12 months.

Complete the below table by collecting data from CAT4. Instructions are available for MBS attendance filters or MBS items Use the appropriate item numbers that are relevant for your practice from the list above.

	Description	Total number of active patients as per RACGP criteria	Total number of active patients
5.1a	Number of patients at high risk eligible for the *My health for life* program *(from activity 1.1)*		

[4] https://www.heartfoundation.org.au/getmedia/12c3a44e-e304-4ebe-8796-1f8b1ce9d73d/200406_MBS-Factsheet-D2.pdf

	Description	Total number of active patients as per RACGP criteria	Total number of active patients
5.1b	Number of indigenous patients eligible for the *My health for life* program *(from activity 1.1)*		
5.1c	Number of health assessment (MBS item 701, 703, 705 & 707) claimed in the past 12 months. *Please note: not all patients will be eligible for a health assessment due to not meeting MBS criteria or age.*		
5.1d	Number of Heart Health Checks (MBS item 699) claimed in the past 12 months		
5.1e	Number of Aboriginal and Torres Strait Islander (MBS item 715) claimed in the past 12 months		

Please note: You may wish to change the dates of your searches to compare previous years and/or different time frames.

Activity 5.2– Review MBS item number claiming at your practice

The aim of this activity is to review your MBS item number claiming for patients who may be eligible for the My health for life program.

Description	Status	Action to be taken
After completing **activity 5.1** are there any unexpected results with your practice's MBS claiming?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. low % of patients eligible for the My health for life program have a heart health check or high % of Aboriginal and Torres strait islander health assessments completed*). How will this information be communicated to the practice team?

Description	Status	Action to be taken
Do relevant team members know the criteria associated with claiming health assessments, heart health checks and Aboriginal and Torres Strait islander assessments?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to information on: • Health Assessments • Heart Health checks • Aboriginal health assessments.
After reviewing your MBS claiming, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

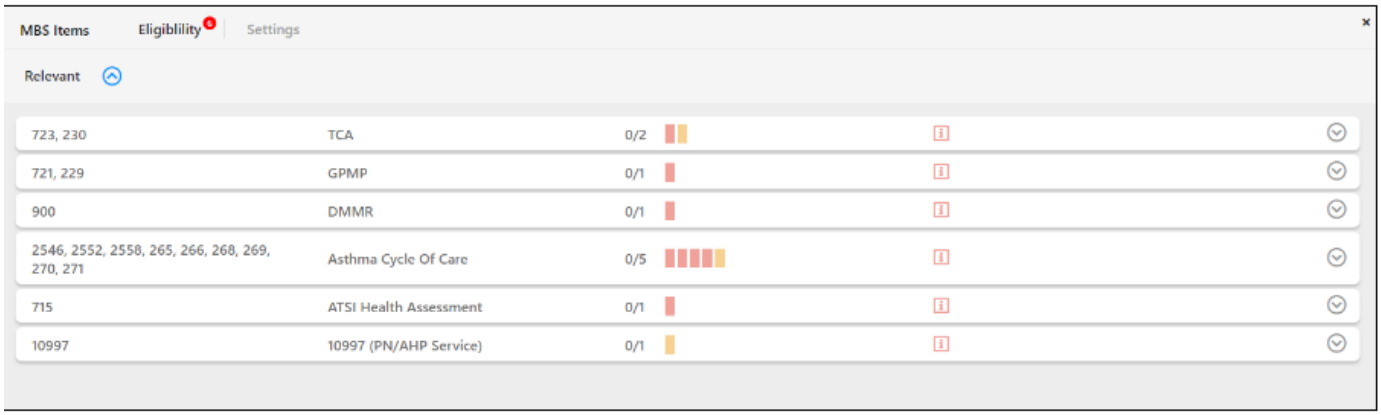
Tools to help utilise MBS item numbers

MBS item numbers and Topbar

Pen CS (PENCS) have developed Topbar as an adjunct to the GP Clinical Desktop System to deliver useful tools and decision support information for the primary care sector at the point of care. Currently Topbar works with Best Practice, MD3 and the latest version of Zedmed.

The MBS app can assist in determining which MBS item is relevant for the patient currently open in the clinical system. Topbar looks at the billing history of the patient at the clinic only - Medicare currently does not allow third party access to information about billing elsewhere.

For each patient that is open on the clinical system, you will be able to view the list of MBS item numbers that the patient is eligible for.



Provider digital access (PRODA)

PRODA is an online authentication system used to securely access certain online services including HPOS. Designed as a two-step verification process, it requires a username, password and verification code to login. Practice staff can use PRODA to search for previous MBS item number billing and to check eligibility.

For more information about Topbar or PRODA:

Brisbane South PHN have some instructions to assist with registration and using the portal.

- Topbar flip guide
- PRODA login
- HPOS education resources
- Health professionals online learning modules.

Activity 6. Recalls and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a comprehensive toolkit to assist you to review your practice recall and reminder systems. You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via DiscoverPHN**.**

Activity 6.1 – Reminder system

The aim of this activity is to review the practice's reminder system.

Description	Status	Action to be taken
Does your practice have routine reminders for appropriate preventive health care for e.g. BP check, glucose tolerance test?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Discuss with clinical team appropriate intervals for reminder categories and create categories
Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Use of a symbol in the appointment book to identify type of appointment.
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 7. *My health for life* resources and training

Guidelines

- RACGP – Guide for prevention in General Practice (Red Book)
- RACGP - Guidelines for secondary prevention of coronary heart disease
- Quick reference guide for health professionals - Absolute cardiovascular disease risk management
- RACGP - National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.

Tools

- *My health for life* risk assessment
- Australian absolute cardiovascular disease risk calculator
- Australian Type 2 diabetes risk assessment calculator
- Heart Online: Heart Education Assessment Rehabilitation Toolkit
- Health and Wellbeing Queensland – Clinicians hub
- Quitline.

Resources

- *My health for life* – program outline
- *My health for life* – eligibility flow chart
- *My health for life* Health Professionals - FAQ
- SpotOnHealth HealthPathways – Lifestyle modification programs
- Heart Foundation - Preventing chronic disease through physical activity
- The Department of Health – Medicare Health Assessment Resource Kit
- RACGP – Conducting quality health assessments in General Practice
- Heart foundation – for health professionals
- Health and Wellbeing Queensland
- Heart Health Toolkit
- 10,000 steps.

Training and information

- APNA cardiovascular disease risk assessment modules
- Motivational Interviewing techniques for health professionals to support health behaviour change
- Aboriginal Health - information and resources for health professionals
- Heart Online - Supporting behaviour change
- APNA - Cardiovascular disease risk assessment and management - Free 2-hour course for nurses
- HotDoc Webinar: Calculating Absolute Cardiovascular Risk & Relevant Health Assessments in General Practice.

How to adopt an absolute risk approach in your practice (5 short interviews with leading experts)

- Absolute risk and what it means in practice (05:24)
- Reducing barriers to using an absolute risk approach (04:17)
- Engaging patients to think about absolute risk (04:58)
- Absolute risk assessment in Aboriginal and Torres Strait Islander populations (02:13)
- Other issues in absolute risk assessment (03:53).

Information for patients:

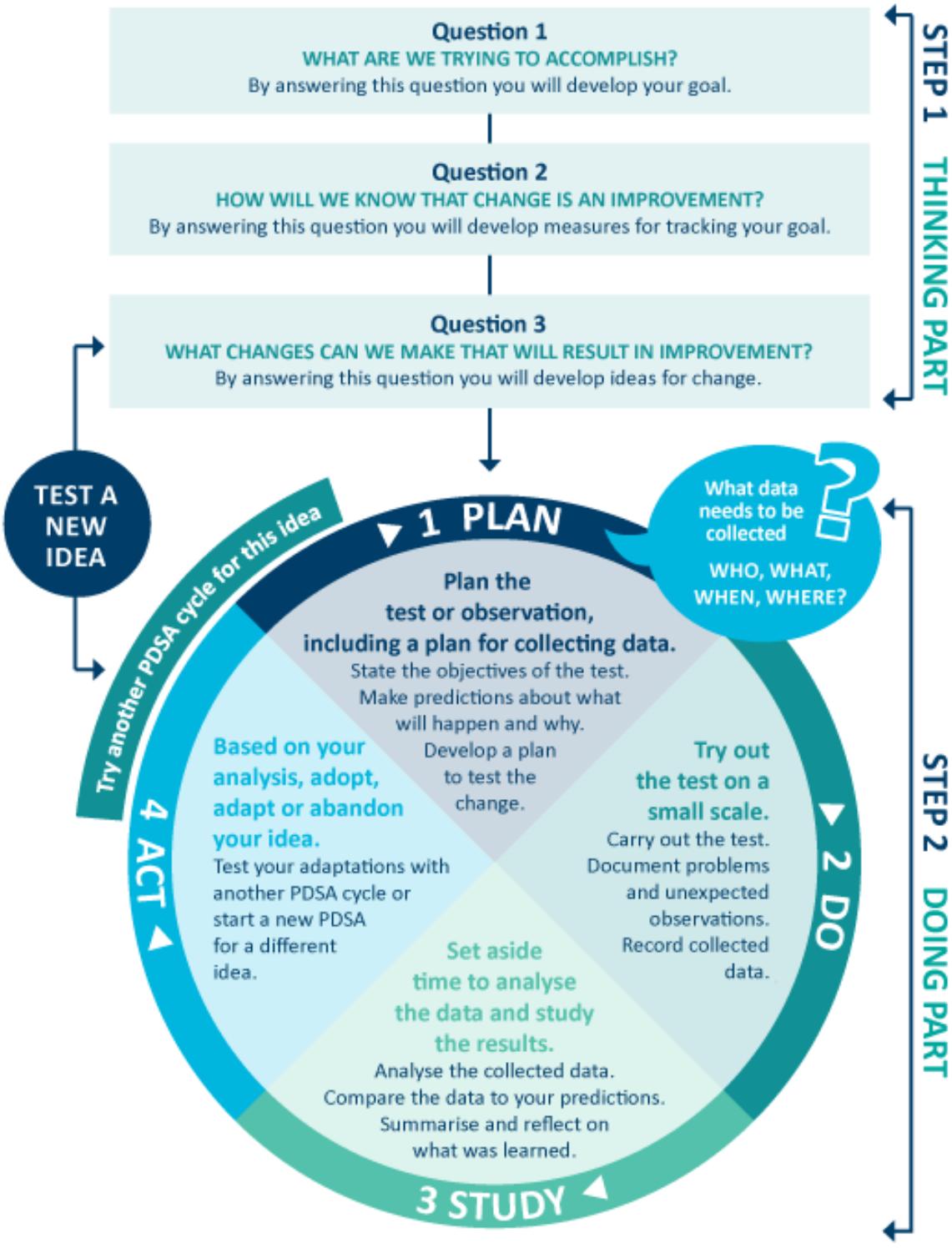
- *My health for life* patient information flyer (mainstream)
- *My health for life* patient information flyer (CALD)
- Heart foundation walking
- Healthier Happier
- Know your risks
- Heart age check poster (PDF)
- Heart health check brochure (PDF)
- Guide to healthy eating for adult brochure
- Quitline - for smoking cessation tools, information and resources
- Family history screening questionnaire.

Example PDSA for *My health for life*

See below for suggested goals related to *My health for life* you may wish to achieve within your practice:

Goal	How you may achieve the goal
Ensure 90% of active patients aged 15 years and older have smoking status recorded as – current smoker, ex-smoker or never smoked.	• Refer to CAT4 recipe: identifying patients with no allergy or smoking status recorded.
Ensure 75% of active patients aged 15 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months.	• Refer to CAT4 recipe: adding, height, weight and waist measurements to patients records.
Increase by 10% the number of patients aged 45 to 74 years with the following risk factors recorded to enable CVD risk assessment: • smoking status • blood pressure • total cholesterol and HDL levels (you may wish to do this as part of a Heart Health Check MBS item 699).	Refer to the following CAT4 recipes: • identify patients with no allergy or smoking status recorded • identify patients with no BP recorded • identify patients with elevated cv risk (select excluded and incomplete tab).

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.
Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to:
Increase the number of *My health for life* referrals for eligible patients.
This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.
So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to increase the number of *My health for life* referrals for patients with high cholesterol eligible for the program by 10% by 30th April.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the number of *My health for life* referrals for patients with high cholesterol eligible for the program. To do this we will:

A) Identify the number of active patients with high cholesterol eligible for the *My health for life* program.

B) Identify the number of active patients with high cholesterol referred to the *My health for life* program.

B divided by A x 100 produces the percentage of patients with high cholesterol who have been referred to the *My health for life* program.

BASELINE MEASUREMENT: 23% of active eligible patients will have a referral to the program DATE:

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients with high cholesterol who are eligible for the *My health for life* program.

IDEA: All patients aged between 40 and 50 years are offered to complete an AUSDRISK questionnaire in the waiting room. This option would capture any under-screened patients.

IDEA: Create a prompt on Topbar to ensure all patients with high cholesterol who are eligible for the *My health for life* program are offered a referral.

IDEA: Clinical team discuss how they can ensure cholesterol results are recorded on targeted population.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active patients with high cholesterol who are eligible for the *My health for life* program.	

PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.

WHAT:
Tom will set aside an hour on a Thursday afternoon to conduct a search on CAT4 of all patients with high cholesterol who are eligible for the *My health for life* program. Individual lists will be created for each GP to highlight patients to contact. Patients will be sent an SMS from the practice with a link to the program and given the option to speak to their GP or self-refer.
WHO/WHEN/WHERE:
Who: Practice manager When: Begin 10th January. Where: Practice manager office.

DATA TO BE COLLECTED: Number of active patients with high cholesterol eligible for the *My health for life* program.

PREDICTION: 15% of active patients with high cholesterol eligible for the *My health for life* program will have been referred to the program.

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).

Done – completed 10th April – individual GP reports were generated from CAT4 outlining patients with high cholesterol eligible for the *My health for life* program. It was identified 3 of the GPs in the practice were unaware of the *My health for life program.* Education and training was provided to the practice team in relation to the program criteria. There was an issue with the SMS being sent, with offering patients the opportunity to self-refer. If patients chose this option, the practice had no way of monitoring the number of referrals being made.

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.

A total of 25% of eligible patients with high cholesterol have been referred to the *My health for life* program.

Results have been shared with the whole practice team.

Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT:

- The practice will continue to focus on this group of patients, however, we will edit the wording in the SMS to encourage patients to attend the practice and not self-refer.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN, 2022

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